Peer review for physiotherapists in Australia: The concept of interpractice visits

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Peer review is a quality assurance tool which offers much to physiotherapists in the 1990s. It continues to be valuable when practised in both formal and informal settings. Over the last decade, peer review has been developed into several formalised processes, enabling physiotherapists to choose the most appropriate method of peer review to suit their mode of practice. The result is an opportunity for physiotherapists to share ideas for improvement in all aspects of physiotherapy practice in a non-threatening, positive environment.

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Despite being one of the earliest quality assurance techniques practised by physiotherapists in Australia (Quality Assurance Kit, ACHS 1984), peer review has not been fully explored because of the potential for punitive action and conflict of interest (Hershey and Bontempo 1990). Given recent work by the Royal Australian College of General Practitioners, which has oriented quality assurance towards group concensus on process and outcome, (Ward 1989, Ward et al 1990), formal peer review is worthy of reconsideration by all members of the physiotherapy profession.

With forethought and planning, creative peer review, such as that described by the RACGP Interpractice Visits concept, will enable physiotherapists isolated by distance, time or specific work demands, to develop solid professional relationships with peers outside the physical confines of the workplace, thus improving personal knowledge and treatment accountability.

Peer review has been defined as 'the evaluation by practising physicians or other professionals, of the effectiveness and efficiency of services ordered or performed by other members of the profession whose work is being reviewed' (Subcommittee on Health and the Environment 1976).

The definition of quality assurance that best incorporates the concept of peer review is that of Legge (1984): 'looking at what we do to and for our patients, thinking about it, judging whether it comes up to certain standards, and if not, trying to improve' (p. 14).

The essence of peer review is that criteria under examination must be established by peer concensus (Dorian 1988). Consensus opinion must be based on both implicit and explicit criteria (Donabedian 1980). Implicit knowledge is that which is accepted and espoused by individual professionals. Explicit knowledge is that expert opinion usually sought from outside the immediate professional group.

Professional opinion from within a group of peers must be merged with expert opinion from outside the group in order to establish concensus criteria which are professionally correct, generally attainable, geographically acceptable, and reflect the professional body's standing within its community (O'Hagan 1986).

The Australian Council of Health Care Standards Hospital Accreditation Program, and the Australian Physiotherapy Association Practice Accreditation Program (1990) are examples of accepted, structurally oriented, peer review by surveying. Concensus criteria for these programs have been developed by combining implicit and explicit criteria, and refining the results by peer discussion.

Throughout their undergraduate education, physiotherapists learn to be comfortable with the concept of peer review. The teaching of clinical techniques involves constant assessment and review by both the

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tutor, and the student's peers (Best 1988, Forster et al 1978, King 1982). Formal peer review, both intradisciplinary and multidisciplinary, can be a natural progression of quality assurance when practised after graduation. However, many health professionals quickly become less comfortable with the benefits of regular peer review after entering the workforce. Competition for patients, fear of exposure of inadequate skills, lack of time, financial constraints, poor acknowledgement of physical and academic limitations and lack of opportunity, all too often present as reasons for not pursuing peer contact (Donabedian 1980, El-Din 1991, Legge 1984).

Physiotherapists who work in large hospitals have the advantage of peer association within the workplace (O'Hagan 1986). Inservice lectures, staff meetings, case presentations, ward rounds and student teaching comprise formal peer review by physiotherapists both within their own discipline and in multidisciplinary settings. Formal peer review within a department can take the form of staff development, or performance appraisals (Best 1988, King 1982, Mullins 1979).

Informal peer review can occur without documentation at shared meal breaks, at informal patient review or during informal corridor chats. The excellence of the information passed on in these situations is marred only by a lack of documentation.

Rotation of staff through the wards exposes the individual physiotherapist's record keeping, clinical skills and outcomes to regular scrutiny. The opportunity exists within the framework of the hospital department for physiotherapists who do not comply with expected levels of performance to be guided by more experienced peers. Mentor systems which link senior and junior physiotherapists in professional and emotional support networks are invaluable to instill the concepts of ongoing peer review, and professional accountability.

Although peer review in large hospitals is often limited to intra-departmental, or, at best, intra-hospital communication, the development of Physiotherapists-In-Management groups is paving the way for the sharing of common inter-hospital physiotherapy department problems. However, few employed physiotherapists avail themselves of peer communication with collegues in similar settings in other hospitals. Solutions to commonly experienced problems at all levels may be found if interpractice visits were established at base grade staff levels between larger hospital physiotherapy departments.

Physiotherapists who work in small hospitals, or in private practice, may not always have ease of access to such a wide cross-section of peers as are available in large hospitals (Ward 1989). To date, professional isolation of individual practitioners has been a source of concern within the Australian physiotherapy profession (Singer et al 1990). Geographical isolation is only one aspect of professional isolation; a more insidious example is where time, family and financial constraints on the physiotherapist preclude peer review at both a professional and personal level.

With guidelines already developed (El-Din 1991, MacInnes 1990, Ward et al 1990), it is possible to establish a process of review by peers in particular geographical areas by way of interpractice visits. The framework for these visits was established by the Tasmanian General Practitioners in 1989, and involves survey protocol generated by concensus by the participants. Peer review created by this approach, can range through various structural aspects of the medical service (such as cleanliness, staff conduct, waiting time, business management and practice facilities), to process and outcome aspects such as the conduct of a patient assessment and the discussion of outcome of intervention. The range of protocols developed by the peer review process includes self assessment, checklist development, structured methods of observation, and positive comment leading to improved personal and professional communication by both the surveyor and the surveyed.

Integral to successful interpractice visits is the earlier establishment and nurturing of the peer group. This group needs to meet regularly in order to develop the concepts of professional sharing, accountability, and acceptable variation in skills and target markets. Participants in the peer review groups are encouraged to present cases, discuss journal articles, or debate professional issues in order to familiarise themselves with the processes of professional dialogue (Anderson 1990). An expectation of these discussion groups is that the communication established may continue past the initial interpractice visit to become ongoing, patient-care oriented, interpractice peer review.

Physiotherapists in Australia have begun to use the process of quality assessment, and quality review, to enhance their marketing strategies to patients, referrers and payers (Beaton 1989, Grimmer et al 1992, O'Keefe et al 1985). They are also confronting issues such as costing treatments, coding diagnosis and intervention, and establishing clinical indicators and critical paths for specific conditions (Collopy 1990). Physiotherapists are more readily dealing with peer review in the form of hospital or private practice accreditation, as well as peer review via external funding agencies such as Department of Veterans Affairs (Gaughwin et al 1991).

It may be but a short step for physiotherapists to evolve a non-threatening peer review rationale which encompasses a group of geographically similar, like-minded practitioners.

Individually generated peer review allows practitioners to address issues of concern to the immediate group, and encourages appropriate continuing eduation, group action on local issues of concern, the development of local databases dealing with the results of intervention, and business rewards such as greater purchasing power. All physiotherapists, be they hospital

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employees or in sole practice would gain from peer association. The single case approach (Riddoch 1991), generally practised by individual practitioners could become a cumulative, population-based concept. The benefits of interpractice peer review, both within and outside the profession, are tangible and marketable.

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